Exhibit B

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Carter, et al. v. Ameridose, et al.,
No. 1:13-cv-12187-FDS, Compl. Ex. A

Deficiency:

Notice of Intent does not include any HIPAA releases[1]

Provision Violated:

Tenn. Code Ann. § 29-26-121(a)(2)(E), which requires a HIPAA release allowing a defendant to obtain "complete" medical records

[1] While the Complaint attaches a HIPAA release that was allegedly sent to Tennessee Defendants, these Tennessee Defendants attest in the affidavit filed with this Memorandum of Law that the HIPAA release was not included with the notice of intent mailed to these Tennessee Defendants. As further proof, and as the Court may notice, the HIPAA release attached to the Plaintiffs' Complaint is not dated, signed, or filled out in any relevant way that would indicate it was included with the Plaintiffs' notice of intent.

Janet, Jenner & Suggs, LLC
ATTORNEYS AT LAW

Howard A. Janet, P.C.* | Kenneth M. Suggs• | Robert K. Jenner, P.C.*±
Dov Apfel*± | Stephen C. Offutt*±= | Giles H. Manley, M.D., J.D.* | Gerald D. Jowers, Jr.• | Brian D. KettererΔ

Sharon R. Guzejko* | Kimberly A. Dougherty◊ | Francis M. Hinson, IV• | Hal J. KleinmanΔ‡ | Tara J. Posner*±† | Elisha N. Hawk*± =
Justin A. Browne* | Joyce E. Jones* | Jessica H. Meeder*± | Leah K. Barron* | Lindsey M. Craig* | Jason B. Penn* ±
Seth L. Cardeli §≠ | Samuel M. Collings*± | William F. Burnham*

OF COUNSEL
John C. Hensley, Jr.• | Steven J. German§≠± | Joel M. Rubenstein§≠ | Thomas G. Wilson≠†•

BAR MEMBERSHIPS
* Maryland | • South Carolina | ◊ Massachusetts | ± District of Columbia | = Minnesota | Δ Pennsylvania
‡ Illinois | † Florida | ° North Carolina | § New York | ≠ New Jersey | ▪ West Virginia | • California

September 3, 2013

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Kenneth R. Lister, M.D.
2761 Sullins Street
Knoxville, TN 37919

Re: Wilma S. Carter and Lawrence Carter
Notice of health care liability claim required by
Tennessee Code Annotated § 29-26-121

To Kenneth R. Lister:

We are the attorneys representing Wilma S. Carter and Lawrence Carter.

Through their attorneys, Wilma S. Carter and Lawrence Carter are asserting a claim for health care liability against Specialty Surgery Center, PLLC, Crossville, Tennessee, and Kenneth R. Lister, M.D., including their agents, employees, physicians, nurses and pharmacists. This potential claim arises out of care, medicines and services provided by you, your employees and/or agents of Specialty Surgery Center, PLLC to Wilma S. Carter from January 2012 through September 2012.

The full name and date of birth of the patient whose treatment is at issue:

Wilma S. Carter
Date of Birth: , 1952

The name and address of the claimant authorizing this notice:

MASSACHUSETTS OFFICE
Kimberly A. Dougherty, Managing Attorney
31 St. James Avenue, Suite 365 | Boston, Massachusetts 02116
617-933-1265 | Fax 410-653-6903 | 1-877-692-3862 | 1-877-MY-ADVOCATES
info@MyAdvocates.com | MyAdvocates.com
Maryland | South Carolina | Massachusetts | New York | North Carolina | Washington, D.C. | West Virginia

Janet, Jenner & Suggs, LLC
ATTORNEYS AT LAW

Wilma S. Carter and Lawrence Carter
1591 Sawmill Road
Crossville, TN 38555

The name and address of the attorney sending this notice:

Kimberly A. Dougherty
Janet, Jenner & Suggs, LLC
31 St. James Avenue, Suite 365
Boston, Massachusetts 02116

Attached hereto is a list of all healthcare providers to whom notice is being given pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(D).

Pursuant to Tennessee Code Annotated § 29-26-121 (a)(2)(E), I also enclose a HIPPA compliant medical authorization permitting you to obtain complete medical records on Wilma S. Carter from each provider being sent a notice. If any of those providers do not accept this authorization for any reason, please contact us and we will arrange to execute an authorization acceptable to them that will permit you to obtain complete medical records on Wilma S. Carter.

Neither this notice nor the medical authorization waives the common law physician patient privilege concerning that care and treatment of Wilma S. Carter by any doctor who provided medical services for Wilma S. Carter. We expect that you will not communicate with any person other than your attorney about any doctor's care and treatment of Wilma S. Carter.

We believe this letter complies with the letter and spirit of Tennessee Code Annotated § 29-26-121. If you believe it is deficient in any way, please let us know and any defect will be promptly cured. If we do not hear from you we will assume that you agree the letter complies with the law.

Very truly yours,

Kimberly A. Dougherty

Enclosures
cc: Wilma S. Carter and Lawrence Carter *(via first-class mail)*
CJ Gideon *(via electronic mail)*

MASSACHUSETTS OFFICE
Kimberly A. Dougherty, Managing Attorney
31 St. James Avenue, Suite 365 | Boston, Massachusetts 02116
617-933-1265 | Fax 410-653-6903 | 1-877-692-3862 | 1-877-MY-ADVOCATES
info@MyAdvocates.com | MyAdvocates.com
Maryland | South Carolina | Massachusetts | New York | North Carolina | Washington, D.C. | West Virginia

The following is a list of all providers to whom notice is being given pursuant to Tennessee Code Annotated § 29-26-121 (a)(2)(D):

Specialty Surgery Center, PLLC
Donathan M. Ivey Registered Agent for Service of Process:
116 Brown Avenue
Crossville, TN 38555-7703

Kenneth R. Lister, M.D.
116 Brown Avenue
Crossville, TN 38555

Kenneth R. Lister, M.D.
2761 Sullins Street
Knoxville, TN 37919

HIPAA RELEASE GENERAL AUTHORIZATION

REQUEST TO: _____

_____

_____

_____

I HEREBY AUTHORIZE _____ to release the information specified below for the date(s): _____ through _____.

THE INFORMATION REQUESTED IS FOR **LITIGATION PURPOSES** AND IS TO BE RELEASED TO:

Robert K. Jenner
Janet, Jenner & Suggs, LLC
Commerce Center
1777 Reisterstown Rd, Suite 165
Baltimore, MD 21208

Rosie Oldham, RN, BS, LNCC
R&G Medical Legal Solutions, LLC
PO Box 5339
Peoria, AZ 85385-5339

INFORMATION TO BE RELEASED

___	Municipal, Governmental, Fire or Police Records	___	Inpatient Date _____	X	X-rays (digital)
		___	Outpatient Date _____	X	X-ray reports
___	Federal or State Tax information or records	X	Emergency Room records	X	ENTIRE RECORD
		___	Face Sheet	X	Billing Records
___	Wage, income or earning records or reports	X	History & Physical		Steroid Injection Information [*e.g.*,
		X	Discharge summary	X	manufacturer, Lot #]
X	Laboratory reports	X	Consultation reports	X	Color copies of any photographs
X	Report and/or records from physician, therapist	X	Surgery & Pathology reports		Test Results [*e.g.*, Spinal
		___	MRIs (digital)	X	Tap]

I understand the requested medical records may include information relating to: **alcohol and/or drug abuse, psychiatric treatment, HIV/Aids testing or treatment, sexually transmitted disease, and/or communicable or noncommunicable disease information.** Such information is covered by Federal Confidentiality Regulation [42CFR, Part 2] and can't be

disclosed without my written consent. I also expressly acknowledge note of this under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulation [45 CFR, § 164.512(e)(l)(ii)]. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. My signature on this form authorizes the release of this information as well as all other requested information in the records.

I understand that I may refuse to sign this authorization and refusal to sign will not affect my ability to obtain treatment, enroll in any health plan or payment/benefit eligibility.

I understand that I may revoke this authorization in writing at any time except for information which may have been disclosed by the above named provider prior to the receipt of such revocation. This authorization is valid for three (3) years. The above named provider should respond to this request, or subsequent requests for information from JANET, JENNER & SUGGS, LLC, R&G Medical Legal Solutions, LLC, or their representatives, at any time unless the above named health care provider receives a written revocation from me.

THIS AUTHORIZATION does allow the named healthcare provider to discuss my health information, history of care or condition with, or be interviewed by, members of the law firm of JANET, JENNER & SUGGS, LLC, and/or R&G Medical Legal Solutions, LLC.

A photocopy of this authorization is to be considered as valid as the original.

Dated: _____ Signature: _____

SSN: _____ Printed Name: _____

DOB: _____ Address: _____

_____

_____

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Brock, et al. v. Ameridose, et al.,
No. 1:13-cv-12731-FDS, Compl. Ex. A

Deficiency:

Release limits Tennessee Defendants to receiving the patient's medical records only for treatment from June 1, 2012, to present or another similar and arbitrary time period

Provision Violated:

Tenn. Code Ann. § 29-26-121(a)(2)(E), which requires a HIPAA release allowing a defendant to obtain "complete" medical records

Exhibit 1

LAW OFFICES OF

GALLIGAN NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: /1947
SS#: 7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: ____ 1947 Social Security Number: ____-7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-25-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Rachel Rome, M.D.
c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
353 New Shackle Island Road
Hendersonville, TN 37075

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
Hermitage, TN 37076

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
Murfreesboro, TN 37129

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Patel, et al. v. Ameridose, et al.,
No. 3:14-cv-12731-FDS, Compl. Ex. 3

Deficiency:

Release only authorizes health care providers to disclose the patient's medical records to the Plaintiffs' law firm

Provision Violated:

Tenn. Code Ann. § 29-26-121(a)(2)(E), which requires a HIPAA release allowing a defendant to obtain "complete" medical records

Janet, Jenner & Suggs, LLC
ATTORNEYS AT LAW

Howard A. Janet, P.C.* | Kenneth M. Suggs* | Robert K. Jenner, P.C.*±
Dov Apfel*± | Stephen C. Offutt*±≈ | Giles H. Manley, M.D., J.D.* | Gerald D. Jowers, Jr.* | Brian D. KettererΔ

Sharon R. Guzejko* | Kimberly A. Dougherty◊ | Francis M. Hinson, IV* | Hal J. KleinmanΔ‡ | Tara J. Posner*±† | Elisha N. Hawk*± ≈
Justin A. Browne* | Joyce E. Jones* | Jessica H. Meeder*± | Leah K. Barron* | Lindsey M. Craig* | Jason B. Penn* ±
Seth L. Cardeli §≈ | Samuel M. Collings*± | William F. Burnham*

OF COUNSEL
John C. Hensley, Jr.° | Steven J. German§≈± | Joel M. Rubenstein§≈ | Thomas G. Wilson≈†•

BAR MEMBERSHIPS
*Maryland | •South Carolina | ◊Massachusetts | ± District of Columbia | ≈ Minnesota | Δ Pennsylvania
‡ Illinois | † Florida | ° North Carolina | § New York | ≈ New Jersey | ≈West Virginia | •California

August 23, 2013

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Saint Thomas Outpatient Neurosurgical Center, LLC
Gregory B. Lanford, M.D. Registered Agent for Service of Process
2011 Murphy Ave., Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
Floor 9
4230 Harding Pike
Nashville, TN 37205-2013

Re: Gokulbhai Maganbhai Patel, deceased
Notice of health care liability claim required by
Tennessee Code Annotated § 29-26-121

To Saint Thomas Outpatient Neurosurgical Center, LLC:

We are the attorneys representing Pinal Patel.

Through his attorneys, Pinal Patel, individually, and as Personal Representative of the Estate of Gokulbhai Maganbhai Patel, is asserting a claim for health care liability against Saint Thomas Outpatient Neurosurgical Center, LLC, Howell Allen Clinic A Professional Corporation, and Vaughan A. Allen, M.D., including their agents, employees, physicians, nurses and pharmacists. This potential claim arises out of care, medicines and services provided by employees and/or agents of Saint Thomas Outpatient Neurosurgical Center, LLC to Gokulbhai Maganbhai Patel from August 2012 through September 2012.

MASSACHUSETTS OFFICE
Kimberly A. Dougherty, Managing Attorney
31 St. James Avenue, Suite 365 | Boston, Massachusetts 02116
617-933-1265 | Fax 410-653-6903 | 1-877-692-3862 | 1-877-MY-ADVOCATES
info@MyAdvocates.com | MyAdvocates.com
Maryland | South Carolina | Massachusetts | New York | North Carolina | Washington, D.C. | West Virginia

Janet, Jenner & Suggs, LLC
ATTORNEYS AT LAW

The full name and date of birth of the patient whose treatment is at issue:

Gokulbhai Maganbhai Patel
Date of Birth: , 1932

The name and address of the claimant authorizing this notice, and their relationship to the patient:

Pinal Patel, Personal Representative of the Estate of Gokulbhai Maganbhai Patel
315 S. Main Street
Goodlettsville, TN 37072

The name and address of the attorney sending this notice:

Kimberly A. Dougherty
Janet, Jenner & Suggs, LLC
31 St. James Avenue, Suite 365
Boston, Massachusetts 02116

Attached hereto is a list of all healthcare providers to whom notice is being given pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(D).

Pursuant to Tennessee Code Annotated § 29-26-121 (a)(2)(E), I also enclose a HIPPA compliant medical authorization permitting you to obtain complete medical records on Gokulbhai Maganbhai Patel from each provider being sent a notice. If any of those providers do not accept this authorization for any reason, please contact us and we will arrange to execute an authorization acceptable to them that will permit you to obtain complete medical records on Gokulbhai Maganbhai Patel.

Neither this notice nor the medical authorization waives the common law physician patient privilege concerning the care and treatment of Gokulbhai Maganbhai Patel by any doctor who provided medical services for Gokulbhai Maganbhai Patel. We expect that you will not communicate with any person other than your attorney about any doctor's care and treatment of Gokulbhai Maganbhai Patel.

We believe this letter complies with the letter and spirit of Tennessee Code Annotated § 29-26-121. If you believe it is deficient in any way, please let us know and any defect will be promptly cured. If we do not hear from you we will assume that you agree the letter complies with the law.

MASSACHUSETTS OFFICE
Kimberly A. Dougherty, Managing Attorney
31 St. James Avenue, Suite 365 | Boston, Massachusetts 02116
617-933-1265 | Fax 410-653-6903 | 1-877-692-3862 | 1-877-MY-ADVOCATES
info@MyAdvocates.com | MyAdvocates.com
Maryland | South Carolina | Massachusetts | New York | North Carolina | Washington, D.C. | West Virginia

Janet, Jenner & Suggs, LLC
ATTORNEYS AT LAW

Very truly yours,

Kimberly A. Dougherty

Enclosures
cc: Pinal Patel (*via first-class mail*)

MASSACHUSETTS OFFICE
Kimberly A. Dougherty, Managing Attorney
31 St. James Avenue, Suite 365 | Boston, Massachusetts 02116
617-933-1265 | Fax 410-653-6903 | 1-877-692-3862 | 1-877-MY-ADVOCATES
info@MyAdvocates.com | MyAdvocates.com

Maryland | South Carolina | Massachusetts | New York | North Carolina | Washington, D.C. | West Virginia

HIPAA RELEASE GENERAL AUTHORIZATION

REQUEST TO: _____

_____

_____

_____

I HEREBY AUTHORIZE _____ to release the information specified below for the date(s): _____ through _____.

THE INFORMATION REQUESTED IS FOR **LITIGATION PURPOSES** AND IS TO BE RELEASED TO:

Robert K. Jenner
Janet, Jenner & Suggs, LLC
Commerce Center
1777 Reisterstown Rd, Suite 165
Baltimore, MD 21208

Rosie Oldham, RN, BS, LNCC
R&G Medical Legal Solutions, LLC
PO Box 5339
Peoria, AZ 85385-5339

INFORMATION TO BE RELEASED

___	Municipal, Governmental, Fire or Police Records	___	Inpatient Date _____	X	X-rays (digital)
		___	Outpatient Date _____	X	X-ray reports
___	Federal or State Tax information or records	X	Emergency Room records	X	ENTIRE RECORD
		___	Face Sheet	X	Billing Records
___	Wage, income or earning records or reports	X	History & Physical		Steroid Injection Information [*e.g.*,
		X	Discharge summary	X	manufacturer, Lot #]
X	Laboratory reports	X	Consultation reports	X	Color copies of any photographs
X	Report and/or records from physician, therapist	X	Surgery & Pathology reports		Test Results [*e.g.*, Spinal
		___	MRIs (digital)	X	Tap]

I understand the requested medical records may include information relating to: **alcohol and/or drug abuse, psychiatric treatment, HIV/Aids testing or treatment, sexually transmitted disease, and/or communicable or noncommunicable disease information.** Such information is covered by Federal Confidentiality Regulation [42CFR, Part 2] and can't be

disclosed without my written consent. I also expressly acknowledge note of this under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulation [45 CFR, § 164.512(e)(l)(ii)]. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. My signature on this form authorizes the release of this information as well as all other requested information in the records.

I understand that I may refuse to sign this authorization and refusal to sign will not affect my ability to obtain treatment, enroll in any health plan or payment/benefit eligibility.

I understand that I may revoke this authorization in writing at any time except for information which may have been disclosed by the above named provider prior to the receipt of such revocation. This authorization is valid for three (3) years. The above named provider should respond to this request, or subsequent requests for information from JANET, JENNER & SUGGS, LLC, R&G Medical Legal Solutions, LLC, or their representatives, at any time unless the above named health care provider receives a written revocation from me.

THIS AUTHORIZATION does allow the named healthcare provider to discuss my health information, history of care or condition with, or be interviewed by, members of the law firm of JANET, JENNER & SUGGS, LLC, and/or R&G Medical Legal Solutions, LLC.

A photocopy of this authorization is to be considered as valid as the original.

Dated: _____ Signature: _____

SSN: _____ Printed Name: _____

DOB: _____ Address: _____

_____

_____

The following is a list of all providers to whom notice is being given pursuant to Tennessee Code Annotated § 29-26-121 (a)(2)(D):

Re: Pinal Patel, Personal Representative of the Estate of Gokulbhai Maganbhai Patel, deceased

Saint Thomas Outpatient Neurosurgical Center, LLC
Gregory B. Lanford, M.D., Registered Agent for Service of Process
2011 Murphy Ave., Ste 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
Floor 9
4230 Harding Pike
Nashville, TN 37205-2013

Howell Allen Clinic A Professional Corporation
Gregory B. Lanford, M.D., Registered Agent for Service of Process
2011 Murphy Ave., Ste 301
Nashville, TN 37203-2023

Vaughan A. Allen, M.D
2011 Murphy Ave., Ste 301
Nashville, TN 37203-2023

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Judd, et al. v. Ameridose, et al.,
No. 1:13-cv-13120-FDS, Compl. Ex. F

Deficiency:

Release does not provide a description of the information to be used or disclosed

Provision Violated:

45 C.F.R. § 164.508(c)(1)(i), which requires a HIPAA release contain a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion

Law Office
of
JON E. JONES

First Tennessee Bank Building
345 South Jefferson Avenue, Suite 400
Cookeville, TN 38501

Jon E. Jones

Andrew R. Binkley, Associate
Patrick Shea Callahan, Associate

Telephone (931) 372-8771
Facsimile (931) 372-8992

Mailing Address:
P.O. Box 699
Cookeville, TN 38503

August 22, 2013

THIS LETTER IS DUPLICATED BECAUSE ADDITIONS WERE MADE TO THE LIST OF PROVIDERS

Saint Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Pike, Floor 9
Nashville, TN 37205-2013

NOTICE REQUIRED
BY *T.C.A.* § 29-26-121
CERTIFIED MAIL/
RETURN RECEIPT REQUESTED

Gentlemen:

Pursuant to *T.C.A.* § 29-26-121, please be advised that I am the attorney representing Kenneth H. Judd (date of birth: [redacted] 1940) of 3000 Burgess Falls Road, Cookeville, Tennessee 38506. Through me Kenneth H. Judd and wife, Judy Judd, are asserting a potential claim for medical malpractice against you. Pursuant to *T.C.A.* § 29-26-121(a), the other health care providers being given notice are set out on the attached list.

As required by *T.C.A.* § 29-26-121(a), an executed HIPAA-compliant medical authorization permitting you to obtain complete medical records regarding this matter is enclosed. If this medical release is not acceptable for any reason, please contact us and we will use our best efforts to execute a form acceptable to you and/or the health care provider that will permit you to obtain complete records concerning Kenneth H. Judd as it relates to this incident. The claim of Judy Judd is derivative.

It is intended that this letter comply with the letter and spirit of *T.C.A.* § 29-26-121. If you believe it is deficient in any way, promptly notify us and any defect will be promptly cured. If we do not promptly hear from you, we will assume you believe this letter complies with the law.

If you claim that another person or entity other than those named on the attached page should be given notice of this claim under the above statute or that any other person or entity was an employer or serves as the principal of any person noticed or that any other person or entity caused or contributed to the damages averred in any way, please advise the undersigned.

We are prepared to reasonably cooperate to resolve this matter in a professional way.

Very truly yours,

LAW OFFICE OF JON E. JONES

Jon E. Jones

JEJ/sas
Enclosures

HIPAA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient/Plan Member Name: **Kenneth H. Judd**	Birth Date: [redacted], 1940	Social Security No.: [redacted]
Provider's/Health Plan's Name & Address: **Saint Thomas Hospital**, 4220 Harding Pike, Nashville, TN 37205-2005; **Saint Thomas West Hospital**, 4220 Harding Pike, Nashville, TN 37205-2005; **Saint Thomas West Hospital**, C/O E. Berry Holt, III, 102 Woodmont Boulevard, Suite 800, Nashville, TN 37205-2221; **Saint Thomas Outpatient Neurosurgical Center, LLC**, 4230 Harding Pike, Fl. 9, Nashville, TN 37205-2013; **Saint Thomas Outpatient Neurosurgical Center, LLC**, C/O Gregory B. Lanford, M.D., 2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023; **Howell Allen Clinic, P.C.**, C/O Gregory B. Lanford, MD., 2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023; **Robert H. Latham, M.D.**, Saint Thomas Hospital, 4220 Harding Road, Nashville, TN 37202; **John W. Culclasure, M.D.**, Howell Allen Clinic, 2011 Murphy Avenue, Suite 301, Nashville, TN 37203; **John W. Culclasure, M.D.**, 1916 Patterson Street, Suite 101, Nashville, TN 37212; **Debra V. Schamberg, R.N.**, Howell Allen Clinic, 2011 Murphy Avenue, Suite 301, Nashville, TN 37203; **Debra V. Schamberg, R.N.**, 2644 Mossdale Drive, Nashville, TN 37217-3904; **Debra V. Schamberg, R.N.**, Saint Thomas Outpatient Neurosurgical Center, LLC, 4230 Harding Pike, Fl. 9, Nashville, TN 37205-2013	Recipient's Name: Saint Thomas Outpatient Neurosurgical Center LLC Address 1: 4230 Harding Pike, Floor 9 Address 2: City: Nashville / State: TN / Zip: 37205-2013	

This authorization will expire on the following: Conclusion of Litigation

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? __ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. X No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
_ All PHI in medical record _ Admission form _ Dictation reports _ Physician orders _ Intake/outtake _ Clinical Test _ Medication Sheets		_ Operative Information _ Cath lab _ Special test/therapy _ Rhythm Strips _ Nursing Information _ Transfer forms _ ER Information		_ Labor/delivery sum. _ OB nursing assess _ Postpartum flow sheet _ Itemized bill: _ UB-92: _ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. _ Other: _____	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

The purpose of the release of my records is for review by "Recipient" named above for which I am granting my authorization. **THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEY.** You may furnish this law firm records that are requested by this office. All medical records obtained by "Recipient" named above pursuant to this authorization shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel **Jon E. Jones, Law Office of Jon E. Jones, P.O. Box 699, Cookeville, TN 38503-0699,** within five (5) days after the records are obtained through the use of this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: August 22, 2013
Print Name of Patient/Plan Member's Representative: Kenneth H. Judd	Relationship to Patient/Plan Member: Self

LIST OF HEALTHCARE PROVIDERS WHOM NOTICE IS BEING GIVEN PURSUANT TO *T.C.A.* § 29-26-121(a) REGARDING PATIENT, KENNETH H. JUDD:

Saint Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

Saint Thomas West Hospital
4220 Harding Pike
Nashville, TN 37205-2005

Saint Thomas West Hospital
C/O E. Berry Holt, III, Registered Agent
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

Saint Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Pike, Floor 9
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
C/O Gregory B. Lanford, M.D., Registered Agent
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, P.C.
C/O Gregory B. Lanford, M.D., Registered Agent
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Robert H. Latham, M.D.
Saint Thomas Hospital
4220 Harding Road
Nashville, TN 37202

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
1916 Patterson Street, Suite 101
Nashville, TN 37203-2145

Debra V. Schamberg, R.N.
2644 Mossdale Drive
Nashville, TN 37217-3904

Debra V. Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Debra V. Schamberg, R.N.
St. Thomas Outpatient Neurosurgical Center
4230 Harding Pike, Floor 9
Nashville, TN 37205-2013

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Sawyers, et al. v. Ameridose, et al.,
No. 1:13-cv-12491-FDS, Compl. Ex. 1

Deficiency:

Release does not state the individuals or organizations authorized to disclose the patient's medical records

Provision Violated:

45 C.F.R. § 164.508(c)(1)(ii), which requires a HIPAA release contain the name or other specific identification of the individuals or organizations authorized to disclose the patient's medical records

CRAIN, SCHUETTE & ASSOCIATES

Larry Crain, Esq.
5214 Maryland Way, Ste. 402
Brentwood, TN 37027
T 615-376-2600
F 615-345-6009
Larry@CSAFirm.com

Admitted in TN, VA, Wash. D.C.

www.CSAFirm.com

Brian Schuette, Esq.
719A Dishman Lane
Bowling Green, KY 42104
T 270-781-7500
F 270-781-7533
Brian@CSAFirm.com

Admitted in KY and TN

July 10, 2013

SENT BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Debra V. Schamberg, RN
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

RE: Notice of potential claim for health care liability, pursuant to Tenn. Code Ann. § 29-26-121

This law firm represents John Charles Sawyers in connection with injuries he sustained from a tainted steroid injection he received on or about September 10, 2012 in Davidson County, Tennessee. Because you may be named as a defendant in a Health Care Liability action filed on behalf of our client, you are entitled to written notice at least sixty (60) days before suit is filed, pursuant to Tenn. Code Ann. § 29-26-121. Below is the information required by the statute:

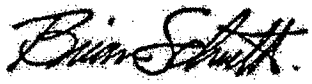
"Full name and date of birth of patient whose treatment is at issue" (*See* Tenn. Code Ann. § 29-26-121(a)(2)(A))	John Charles Sawyers 845 Meador Port Oliver Road Scottsville, KY 42164 Date of Birth: . , 1949
"The name and address of the claimant authorizing the notice and the relationship to the patient, if the notice is not sent by the patient" (*See* Tenn. Code Ann. § 29-26-121(a)(2)(B))	Same as above.
"The name and address of the attorney sending the notice, if applicable" (*See* Tenn. Code Ann. § 29-26-121(a)(2)(C))	Brian Schuette, BPR# 19261 Crain, Schuette & Associates 719A Dishman Lane Bowling Green, KY 42104 (270) 781-7500 Voice (270) 781-7533 Facsimile Brian@CSAFirm.com
"A list of the name and address of all providers being sent a notice" (*See* Tenn. Code Ann. § 29-26-121(a)(2)(D))	See attached

"A HIPAA compliant medical authorization permitting the provider receiving the notice to obtain complete medical records from each other provider being sent a notice." (*See* Tenn. Code Ann. § 29-26-121(a)(2)(E))	See attached.

If you have any questions, please contact the undersigned.

Sincerely,

CRAIN, SCHUETTE & ASSOCIATES

By: 

Brian Schuette
Brian@CSAFirm.com

All Providers Being Sent A Notice

St. Thomas Outpatient Neurosurgical Center, LLC
Gregory B. Lanford, M.D., Registered Agent
2011 Murphy Avenue, Ste 301
Nashville, TN 37203-2023

St. Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Pike
Medical Plaza East, Ste 901
Nashville, TN 37205

St. Thomas Outpatient Neurosurgical Center, LLC
a/k/a St. Thomas Outpatient Neurosurgery Center/Clinic
c/o Matthew H. Cline
Gideon, Cooper & Essary, PLC
Regions Center, Suite 1100
315 Deadrick Street
Nashville, TN 37238

Debra V. Schamberg, RN
Saint Thomas Outpatient Neurosurgical Center
4230 Harding Pike, Ste 901
Nashville, TN 37205

St. Thomas Health Foundations
E. Berry Holt, III, Registered Agent
102 Woodmont Boulevard, Ste 800
Nashville, TN 37205-2221

St. Thomas Health Foundations
Attn: Dawn Rudolph
Chief Executive Officer
4220 Harding Pike
Nashville, TN 37205
Saint Thomas Health
c/o E. Berry Holt, III
102 Woodmont Boulevard, Ste 800
Nashville, TN 37205-2221

Saint Thomas Health
102 Woodmont Boulevard, Ste 800
Nashville, TN 37205-2221

St. Thomas Hospital
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

Saint Thomas Health
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

Saint Thomas Network
4220 Harding Pike
Nashville, TN 37205-2005

New England Compounding Pharmacy, Inc.
(Business Address is same)
Gregory Conigliaro, Registered Agent
697 Waverly Street
Framingham, MA 01701

Ameridose LLC
(Business Address is same)
Gregory Conigliaro, Resident (Registered) Agent
205 Flanders Road
Westborough, MA 01581

Gregory Conigliaro
205 Flanders Road
Westborough, MA 01581

Barry Cadden
205 Flanders Road
Westborough, MA 01581

Howell Allen Clinic
(Business Address is same)
Attn: Gregory B. Lanford, M.D.
Registered Agent
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Debra V. Schamberg, RN
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Patricia G. Beckham
Baptist Women's Pavilion
2011 Murphy Avenue
Nashville, TN 37203

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA C.F.R. 164.512

I authorize the use/disclosure of health information as described below.

1. Person(s) or class of persons, medical provider or other entity or person authorized to disclose the information: _____

2. Person(s) or class of persons or provider, company or entity to whom the information may be disclosed: DEBRA V. SCHAMBERG, RN

3. I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.

4. Description of information to be disclosed: Medical records and reports, patient information and history forms, x-rays, x-ray report, pathology, pathology reports, insurance records, health care providers' reports and consultations, prescriptions, off-work slips, therapy records, lab reports, notes, tests and billing records and statements.

5. The information will be used/disclosed for the following purposes: For medical providers and any other person or entity to obtain medical records for the purpose of determining what happened to John Charles Sawyers and what persons, manufacturers, distributors, purchasers or entities are responsible for causing injury to Mr. Sawyers and for any other lawful purpose.

6. I understand that the health information described above may be redisclosed and no longer protected by federal and state privacy regulations.

7. I understand that my healthcare or payment for healthcare will not be affected if I refuse to sign this authorization.

8. In consideration of the release of information by _____, in accordance with this request, I hereby release _____, its agents, servants, and employees from any and all claims, demands, or liability of any kind, which might arise of or from the release of such information and the effects thereof.

I understand that I have the right to revoke this authorization in writing at any time by sending written notice of revocation to the person(s), class of persons or provider, company or entity at the above address. I understand my revocation of this authorization will not be effective as to uses and/or disclosures of any information that the person(s) and/or organization have previously provided. A copy of this signed release shall be deemed as effective as if it were the original.

This authorization shall expire two years from the date of its execution.

JOHN CHARLES SAWYERS

John Charles Sawyers

DOB: 1949
S.S. NO: -3457

DATE: 7-10-13

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Besaw, et al. v. Ameridose, et al.,
No. 1:13-cv-12604-FDS, Compl. Ex. 7A

Deficiency:

Release does not state the individuals or organizations authorized to receive the patient's medical records

Provision Violated:

45 C.F.R. § 164.508(c)(1)(iii), which requires a HIPAA release contain the name or other specific identification of the individuals or organizations authorized to receive the patient's medical records

English Lucas Priest & Owsley, LLP | *Strength. Knowledge. Experience.*

Writer's e-mail address: byoung@elpolaw.com

June 27, 2013

Via Certified Mail

St. Thomas Outpatient Neurosurgical Center, LLC
a/k/a St. Thomas Outpatient Neurosurgery Center/Clinic
c/o Matthew H. Cline
Gideon, Cooper & Essary, PLC
Regions Center, Suite 1100
315 Deadrick Street
Nashville, Tennessee 37238

Re: Travis Besaw
121 Rosie Street
Bowling Green, Kentucky 42103
DOB: /1982

To Whom It May Concern:

The below is a list of health care providers to whom notice is being given, pursuant to T.C.A. §29-26-121(a), of a potential claim for medical malpractice involving steroid injections administered at St. Thomas Outpatient Neurosurgical Clinic between May 21, 2012 and September 28, 2012.

1. St. Thomas Outpatient Neurosurgical Center, LLC
a/k/a St. Thomas Outpatient Neurosurgery Center/Clinic
c/o Matthew H. Cline
Gideon, Cooper & Essary, PLC
Regions Center, Suite 1100
315 Deadrick Street
Nashville, Tennessee 37238

2. New England Compounding Pharmacy, Inc.
c/o Daniel Cohn, Esq.
Murtha Cullina, LLP
99 High Street, 20th Floor
Boston, MA 02110

3. Ameridose LLC
   c/o Jane F. Warner
   Tucker Ellis LLP
   925 Euclid Avenue, Suite 1150
   Cleveland, Ohio 44115-1414

4. Gregory Conigliaro
   205 Flanders Road
   Westborough, MA 01581

5. Barry Cadden
   205 Flanders Road
   Westborough, MA 01581

6. John Culclasure, M.D.
   Howell Allen Clinic
   2011 Murphy Avenue, Suite 301
   Nashville, TN 37203

7. Howell Allen Clinic
   Attn: Gregory B. Lanford, M.D.
   Registered Agent
   2011 Murphy Avenue, Suite 301
   Nashville, TN 37203

8. St. Thomas Hospital
   Attn: Dawn Rudolph
   Chief Executive Officer
   4220 Harding Road
   Nashville, TN 37205

9. Saint Thomas Network
   4220 Harding Pike
   Nashville, TN 37205-2005

10. Saint Thomas Network
    c/o E. Berry Holt, III
    102 Woodmont Boulevard, Suite 800
    Nashville, TN 37205-2221

Exhibit 7A

11. Saint Thomas Health
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

12. Saint Thomas Health
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

13. St. Thomas Hospital
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

14. St. Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

15. St. Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Pike, Suite 901
Nashville, TN 37205

16. Debra V. Schamberg, RN
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

17. Debra V. Schamberg, RN
Saint Thomas Outpatient Neurosurgical Center
4230 Harding Pike, Suite 901
Nashville, TN 37205

18. Patricia G. Beckham
Baptist Women's Pavilion
2011 Murphy Avenue
Nashville, TN 37203

Please give me a call if you have any questions.

Very truly yours,

ENGLISH, LUCAS, PRIEST & OWSLEY, LLP

Robert A. Young

RAY/tg

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Travis Besaw	/1982	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Out-Patient Neurosurgery Center	

Provider's/Health Plan's Address:	Address 1:		
4230 Harding Pike Medical Plaza East, Suite 810 Nashville, TN 37205	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestee or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 1/2/13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Travis Besaw	/1982	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Out-Patient Neurosurgery Center	
Provider's/Health Plan's Address: 4230 Harding Pike, Medical Plaza East, Suite 810, Nashville, TN 37205	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☑ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic (films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 1/2/13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Travis Besaw	/1982	
Provider's/Health Plan's Name:	Recipient's Name:	
Howell Allen Clinic		
Provider's/Health Plan's Address:	Address 1:	
2011 Murphy Ave., Suite 301 Nashville, TN 37203	Address 2:	
	City: / State: / Zip:	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing information ☑ Transfer forms ☑ ER information		☑ Labor/delivery sum ☑ OB nursing assess ☑ Postpartum flow sheets ☑ Itemized bill ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 11/2/13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Travis Besaw	/1982	

Provider's/Health Plan's Name:	Recipient's Name:
Howell Allen Clinic	
Provider's/Health Plan's Address: 2011 Murphy Avenue, Suite 301 Nashville, TN 37203	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☑ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess. ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic (labs, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 1/2/13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Siler, et al. v. Ameridose, et al.,
No. 1:13-cv-12489-FDS;

Tyree, et al. v. Ameridose, et al.,
No. 1:13-cv-12479

Deficiency:

Release does not state the purpose of the disclosure[2]

Provision Violated:

45 C.F.R. § 164.508(c)(1)(iv), which requires a HIPAA release contain a description of the purpose of the disclosure

[2] Plaintiffs in *Siler* and *Tyree* did not attach their HIPAA releases to their Complaints in violation of Tenn. Code Ann. § 29-26-121(b). Failure to comply with Tenn. Code Ann. § 29-26-121(b) is an independent ground for dismissal. *Vaughn v. Mountain States Health Alliance,* No. E2012-01042-COA-R3-CV, 2013 WL 817032, at *6 (Tenn. Ct. App. March 5, 2013); *Miller v. Uchendu*, No. 2:13-cv-02149-JPM-dkv, 2013 WL 4097340, at *5 (W.D. Tenn. Aug. 13, 2013). Therefore, the Plaintiffs' Complaints in *Siler* and *Tyree* should be dismissed for failure to comply with Tenn. Code Ann. § 29-26-121(a)(2)(E) and (b), amongst the other grounds identified in Exhibit A.

Beasley Allen
BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.
Attorneys at law

218 COMMERCE STREET
POST OFFICE BOX 4160
MONTGOMERY, ALABAMA 36103-4160
(334) 269-2343
(800) 898-2034
FAX: (334) 954-7555
BEASLEYALLEN.COM

W. Roger Smith
Roger.Smith@BeasleyAllen.com

August 28, 2013

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Howell Allen Clinic c/o Gregory B. Lanford, M.D., Agent for Service
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Certified Article Number
7160 3901 9849 1680 2755
SENDERS RECORD

Re: **Tracey Privitt Siler**
Notice of Health Care Liability Claim Required by Tennessee Code Annotated §29-26-121 and Insurance Carrier Notice of Claims

To Dr. Gregory B. Lanford:

Beasley Allen and the Zamora Firm are the attorneys representing Tracey Siler and her husband, Chris Siler. Through her attorneys, this client asserts potential claims for healthcare liability against Howell Allen Clinic, including its agents, employees, physicians, nurses and pharmacists.

This potential claim arises out of care, medicines and services provided by employees and/or agents of Howell Allen Clinic to this client from September 7, 2012 through October 9, 2012.

The full name and date of birth of the patient whose treatment is at issue is:

Name: Tracey Siler
Date of Birth: /68
The names and address of the claimants authorizing this notice:
Tracey and Chris Siler
599 Loop Road
Big Sandy, Tennessee 38221

The name and address of the attorneys sending this notice:
W. Roger Smith
Beasley, Allen, Crow, Methvin, Portis & Miles, P.C.
218 Commerce Street
Montgomery, Alabama 36104

Mark Zamora
Zamora Firm as Co-Counsel
P.O. Box 660216
Atlanta, Georgia 30366

Additionally I am writing to place you on notice of claims by our client who has suffered personal injury and has incurred medical and other expenses as a result of receiving drugs that were compounded by New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center. Our client hereby asserts claims for product liability, negligence, breach of warranty, and misrepresentation associated with such drugs and the treatment received. Please promptly provide a copy of this notice to all carriers who may potentially provide you with insurance coverage for these claims.

Attached hereto is a list of all healthcare providers to whom notice is being given, pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(D).

Pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(E), I also enclose a HIPAA compliant medical authorization permitting you to obtain complete medical records on our client, from each provider being sent a notice. If any of those providers do not accept this authorization for any reason, please contact us and we will arrange to execute an authorization acceptable to them that will permit you to obtain complete medical records for our client.

Neither this notice nor the medical authorization waives the common law physician-patient privilege concerning the care and treatment of our client by any doctor who provided medical services for our client. We expect that you will not communicate with any person, other than your attorney, about any doctor's care and treatment of our client.

We believe this letter complies with the letter and spirit of Tennessee Code Annotated § 29-26-121. If you believe it is deficient in any way, please let us know and any defect will be promptly cured. If we do not hear from you, we will assume that you agree the letter complies with the law.

Yours truly,

BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.

Roger Smith

W. ROGER SMITH and MARK ZAMORA AND ASSOCIATES, CO-COUNSEL

WRS/ccp
Enclosures

LIST OF ALL HEALTHCARE PROVIDERS TO WHOM NOTICE IS BEING GIVEN PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 29-26-121(a)(2)(D)

Re:Tracey Siler and Chris Siler, Husband

Dr. Wayne McGee
1323 East Wood Street
Paris, Tennessee 38242

Dr. Wayne McGee
East Wood Clinic c/o Scott Summers, M.D., Agent for Service
1323 East Wood Street
Paris, Tennessee 38242

East Wood Clinic
c/o Scott Summers, M.D.
1323 East Wood Street
Paris, Tennessee 38242

Dr. Tim Schoettle
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Dr. Tim Schoettle
Howell Allen Clinic c/o Gregory B. Lanford, M.D., Agent for Service
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Howell Allen Clinic c/o Gregory B. Lanford, M.D., Agent for Service
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Dr. Robert Latham
4220 Harding Pike
Nashville, Tennessee 37205

Dr. Robert Latham
c/o St. Thomas Infectious Disease
4220 Harding Pike
Nashville, Tennessee 37205

St. Thomas Infectious Disease
4220 Harding Pike
Nashville, Tennessee 37205

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Tracey Privitt | Patient Identifier:

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider Howell Allen Clinic

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

or any representative, attorney or investigator from said organization or person.

Purpose of the Requested Use or Disclosure

Expiration and Revocation of This Authorization

Expiration Date or Event: _____

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

X Tracey Privitt Liles 22 Aug. 2013
Signature (Patient) Date

Signature (Authorized Representative) Date

X Karl S Taylor
Signature (Witness)

Colleague
Relationship to Patient

Rec'd 8/13/13

Beasley Allen
BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.
Attorneys at law

218 COMMERCE STREET
POST OFFICE BOX 4160
MONTGOMERY, ALABAMA 36103-4160
(334) 269-2343
(800) 898-2034
FAX: (334) 954-7555
BEASLEYALLEN.COM

W. Roger Smith
Roger.Smith@BeasleyAllen.com

SC 28417

August 5, 2013

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D., registered agent for service of process
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Certified Article Number
7160 3901 9849 1580 3684
SENDERS RECORD

Saint Thomas Outpatient Neurological Center, LLC
Floor 9
Harding Pike
Nashville, Tennessee 37205-2013

Re: **Phillip Tyree**
Notice of Health Care Liability Claim Required by Tennessee Code Annotated §29-26-121 and Insurance Carrier Notice of Claims

To Saint Thomas Outpatient Neurosurgical Center, LLC:

Beasley Allen and the Zamora Firm are the attorneys representing Phillip Tyree and his wife, Maria-Fe Tyree. Through his attorneys, this client asserts potential claims for healthcare liability against St. Thomas Outpatient Neurosurgical Center, LLC, including its agents, employees, physicians, nurses and pharmacists.

This potential claim arises out of care, medicines and services provided by employees and/or agents of Saint Thomas Outpatient Neurosurgical Center, LLC , to this client from August 17, 2012 through August 31, 2012.

The full name and date of birth of the patient whose treatment is at issue is:

Name: Phillip Tyree
Date of Birth: , 1952
The names and address of the claimants authorizing this notice:
Phillip and Maria-Fe Tyree Tyree
799 AB Tyree Road
Lewisburg, Kentucky 42256

The name and address of the attorneys sending this notice:

W. Roger Smith
Beasley, Allen, Crow, Methvin, Portis & Miles, P.C.
218 Commerce Street
Montgomery, Alabama 36104

Mark Zamora
Zamora Firm as Co-Counsel
P.O. Box 660216
Atlanta, Georgia 30366

Additionally I am writing to place Saint Thomas Outpatient Neurosurgical Center, LLC, on notice of claims by our client who has suffered personal injury and has incurred medical and other expenses as a result of receiving drugs that were compounded by New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center. Our client hereby asserts claims for product liability, negligence, breach of warranty, and misrepresentation associated with such drugs and the treatment received. Please promptly provide a copy of this notice to all carriers who may potentially provide you with insurance coverage for these claims.

Attached hereto is a list of all healthcare providers to whom notice is being given, pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(D).

Pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(E), I also enclose a HIPAA compliant medical authorization permitting you to obtain complete medical records on our client, from each provider being sent a notice. If any of those providers do not accept this authorization for any reason, please contact us and we will arrange to execute an authorization acceptable to them that will permit you to obtain complete medical records for our client.

Neither this notice nor the medical authorization waives the common law physician-patient privilege concerning the care and treatment of our client by any doctor who provided medical services for our client. We expect that you will not communicate with any person, other than your attorney, about any doctor's care and treatment of our client.

We believe this letter complies with the letter and spirit of Tennessee Code Annotated § 29-26-121. If you believe it is deficient in any way, please let us know and any defect will be promptly cured. If we do not hear from you, we will assume that you agree the letter complies with the law.

Yours truly,

BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.

W. ROGER SMITH and MARK ZAMORA AND ASSOCIATES, CO-COUNSEL

WRS/ccp
Enclosures

LIST OF ALL HEALTHCARE PROVIDERS TO WHOM NOTICE IS BEING GIVEN PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 29-26-121(a)(2)(D)

Re: Phillip Tyree and Maria-Fe Tyree, Wife of Phillip Tyree

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D., Registered Agent for Service of Process
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Saint Thomas Outpatient Neurological Center, LLC
4230 Harding Pike, Suite 901
Nashville, Tennessee 37205-2013

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D., Registered Agent for Service of Process
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

John Weeks Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203

John Weeks Culclasure, M.D.
Saint Thomas Outpatient Neurological Center
4230 Harding Pike, Suite 901
Nashville, Tennessee 37205

Debra V. Schamberg, R.N.
Nashville, Tennessee 37217

Debra V. Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203

Debra V. Schamberg, R.N.
Saint Thomas Outpatient Neurological Center
4230 Harding Pike, Suite 901
Nashville, Tennessee 37205

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Phillip Tyree Patient Identifier:

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider Saint Thomas Outpatient Neurological Center

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

or any representative, attorney or investigator from said organization or person.

Purpose of the Requested Use or Disclosure

Expiration and Revocation of This Authorization

Expiration Date or Event: _____

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

X Phillip R Tyree 8-8-2013
Signature (Patient) Date

X Shatika Boards 8-8-13
Signature (Witness)

Signature (Authorized Representative) Date

Relationship to Patient

MZ784675-ATN

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Siler, et al. v. Ameridose, et al.,
No. 1:13-cv-12489-FDS

Tyree, et al. v. Ameridose, et al.,
No. 1:13-cv-12479

Deficiency:

Release does not include an expiration date or termination event[3]

Provision Violated:

45 C.F.R. § 164.508(c)(1)(v), which requires a HIPAA release contain an expiration date or termination event

[3] Plaintiffs in *Siler* and *Tyree* did not attach their HIPAA releases to their Complaints in violation of Tenn. Code Ann. § 29-26-121(b). Failure to comply with Tenn. Code Ann. § 29-26-121(b) is an independent ground for dismissal. *Vaughn v. Mountain States Health Alliance,* No. E2012-01042-COA-R3-CV, 2013 WL 817032, at *6 (Tenn. Ct. App. March 5, 2013); *Miller v. Uchendu*, No. 2:13-cv-02149-JPM-dkv, 2013 WL 4097340, at *5 (W.D. Tenn. Aug. 13, 2013). Therefore, the Plaintiffs' Complaints in *Siler* and *Tyree* should be dismissed for failure to comply with Tenn. Code Ann. § 29-26-121(a)(2)(E) and (b), amongst the other grounds identified in Exhibit A.

Beasley Allen
BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.
Attorneys at law

218 COMMERCE STREET
POST OFFICE BOX 4160
MONTGOMERY, ALABAMA 36103-4160
(334) 269-2343
(800) 898-2034
FAX: (334) 954-7555
BEASLEYALLEN.COM

W. Roger Smith
Roger.Smith@BeasleyAllen.com

August 28, 2013

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Howell Allen Clinic c/o Gregory B. Lanford, M.D., Agent for Service
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Certified Article Number
7160 3901 9849 1580 2755
SENDERS RECORD

Re: **Tracey Privitt Siler**
Notice of Health Care Liability Claim Required by Tennessee Code Annotated §29-26-121 and Insurance Carrier Notice of Claims

To Dr. Gregory B. Lanford:

Beasley Allen and the Zamora Firm are the attorneys representing Tracey Siler and her husband, Chris Siler. Through her attorneys, this client asserts potential claims for healthcare liability against Howell Allen Clinic, including its agents, employees, physicians, nurses and pharmacists.

This potential claim arises out of care, medicines and services provided by employees and/or agents of Howell Allen Clinic to this client from September 7, 2012 through October 9, 2012.

The full name and date of birth of the patient whose treatment is at issue is:

Name: Tracey Siler
Date of Birth: 58
The names and address of the claimants authorizing this notice:
Tracey and Chris Siler
599 Loop Road
Big Sandy, Tennessee 38221

The name and address of the attorneys sending this notice:
W. Roger Smith
Beasley, Allen, Crow, Methvin, Portis & Miles, P.C.
218 Commerce Street
Montgomery, Alabama 36104

Mark Zamora
Zamora Firm as Co-Counsel
P.O. Box 660216
Atlanta, Georgia 30366

Additionally I am writing to place you on notice of claims by our client who has suffered personal injury and has incurred medical and other expenses as a result of receiving drugs that were compounded by New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center. Our client hereby asserts claims for product liability, negligence, breach of warranty, and misrepresentation associated with such drugs and the treatment received. Please promptly provide a copy of this notice to all carriers who may potentially provide you with insurance coverage for these claims.

Attached hereto is a list of all healthcare providers to whom notice is being given, pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(D).

Pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(E), I also enclose a HIPAA compliant medical authorization permitting you to obtain complete medical records on our client, from each provider being sent a notice. If any of those providers do not accept this authorization for any reason, please contact us and we will arrange to execute an authorization acceptable to them that will permit you to obtain complete medical records for our client.

Neither this notice nor the medical authorization waives the common law physician-patient privilege concerning the care and treatment of our client by any doctor who provided medical services for our client. We expect that you will not communicate with any person, other than your attorney, about any doctor's care and treatment of our client.

We believe this letter complies with the letter and spirit of Tennessee Code Annotated § 29-26-121. If you believe it is deficient in any way, please let us know and any defect will be promptly cured. If we do not hear from you, we will assume that you agree the letter complies with the law.

Yours truly,

BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.

Roger Smith

W. ROGER SMITH and MARK ZAMORA AND ASSOCIATES, CO-COUNSEL

WRS/ccp
Enclosures

LIST OF ALL HEALTHCARE PROVIDERS TO WHOM NOTICE IS BEING GIVEN PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 29-26-121(a)(2)(D)

Re:Tracey Siler and Chris Siler, Husband

Dr. Wayne McGee
1323 East Wood Street
Paris, Tennessee 38242

Dr. Wayne McGee
East Wood Clinic c/o Scott Summers, M.D., Agent for Service
1323 East Wood Street
Paris, Tennessee 38242

East Wood Clinic
c/o Scott Summers, M.D.
1323 East Wood Street
Paris, Tennessee 38242

Dr. Tim Schoettle
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Dr. Tim Schoettle
Howell Allen Clinic c/o Gregory B. Lanford, M.D., Agent for Service
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Howell Allen Clinic c/o Gregory B. Lanford, M.D., Agent for Service
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Dr. Robert Latham
4220 Harding Pike
Nashville, Tennessee 37205

Dr. Robert Latham
c/o St. Thomas Infectious Disease
4220 Harding Pike
Nashville, Tennessee 37205

St. Thomas Infectious Disease
4220 Harding Pike
Nashville, Tennessee 37205

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Tracey Privitt | Patient Identifier:

Description of Information. Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider Howell Allen Clinic

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Persons or Organizations Authorized to Receive the Information

or any representative, attorney or investigator from said organization or person.

Purpose of the Requested Use or Disclosure

Expiration and Revocation of This Authorization

Expiration Date or Event: _____

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

_____

_____

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

X Tracey Privitt Like 22 Aug. 2013
Signature (Patient) Date

X Karl S Taylor
Signature (Witness)

_____
Signature (Authorized Representative) Date

Colleague
Relationship to Patient

Rcd 8/13/13

Beasley Allen
BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.
Attorneys at law

218 COMMERCE STREET
POST OFFICE BOX 4160
MONTGOMERY, ALABAMA 36103-4160
(334) 269-2343
(800) 898-2034
FAX: (334) 954-7555
BEASLEYALLEN.COM

W. Roger Smith
Roger.Smith@BeasleyAllen.com

SC 28417

August 5, 2013

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D., registered agent for service of process
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Certified Article Number
7160 3901 9849 1580 3684
SENDERS RECORD

Saint Thomas Outpatient Neurological Center, LLC
Floor 9
Harding Pike
Nashville, Tennessee 37205-2013

Re: **Phillip Tyree**
Notice of Health Care Liability Claim Required by Tennessee Code Annotated §29-26-121 and Insurance Carrier Notice of Claims

To Saint Thomas Outpatient Neurosurgical Center, LLC:

Beasley Allen and the Zamora Firm are the attorneys representing Phillip Tyree and his wife, Maria-Fe Tyree. Through his attorneys, this client asserts potential claims for healthcare liability against St. Thomas Outpatient Neurosurgical Center, LLC, including its agents, employees, physicians, nurses and pharmacists.

This potential claim arises out of care, medicines and services provided by employees and/or agents of Saint Thomas Outpatient Neurosurgical Center, LLC , to this client from August 17, 2012 through August 31, 2012.

The full name and date of birth of the patient whose treatment is at issue is:

Name: Phillip Tyree
Date of Birth: , 1952
The names and address of the claimants authorizing this notice:
Phillip and Maria-Fe Tyree Tyree
799 AB Tyree Road
Lewisburg, Kentucky 42256

The name and address of the attorneys sending this notice:

W. Roger Smith
Beasley, Allen, Crow, Methvin, Portis & Miles, P.C.
218 Commerce Street
Montgomery, Alabama 36104

Mark Zamora
Zamora Firm as Co-Counsel
P.O. Box 660216
Atlanta, Georgia 30366

Additionally I am writing to place Saint Thomas Outpatient Neurosurgical Center, LLC, on notice of claims by our client who has suffered personal injury and has incurred medical and other expenses as a result of receiving drugs that were compounded by New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center. Our client hereby asserts claims for product liability, negligence, breach of warranty, and misrepresentation associated with such drugs and the treatment received. Please promptly provide a copy of this notice to all carriers who may potentially provide you with insurance coverage for these claims.

Attached hereto is a list of all healthcare providers to whom notice is being given, pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(D).

Pursuant to Tennessee Code Annotated § 29-26-121(a)(2)(E), I also enclose a HIPAA compliant medical authorization permitting you to obtain complete medical records on our client, from each provider being sent a notice. If any of those providers do not accept this authorization for any reason, please contact us and we will arrange to execute an authorization acceptable to them that will permit you to obtain complete medical records for our client.

Neither this notice nor the medical authorization waives the common law physician-patient privilege concerning the care and treatment of our client by any doctor who provided medical services for our client. We expect that you will not communicate with any person, other than your attorney, about any doctor's care and treatment of our client.

We believe this letter complies with the letter and spirit of Tennessee Code Annotated § 29-26-121. If you believe it is deficient in any way, please let us know and any defect will be promptly cured. If we do not hear from you, we will assume that you agree the letter complies with the law.

Yours truly,

BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.

W. ROGER SMITH and MARK ZAMORA AND ASSOCIATES, CO-COUNSEL

WRS/ccp
Enclosures

LIST OF ALL HEALTHCARE PROVIDERS TO WHOM NOTICE IS BEING GIVEN PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 29-26-121(a)(2)(D)

Re: Phillip Tyree and Maria-Fe Tyree, Wife of Phillip Tyree

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D., Registered Agent for Service of Process
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

Saint Thomas Outpatient Neurological Center, LLC
4230 Harding Pike, Suite 901
Nashville, Tennessee 37205-2013

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D., Registered Agent for Service of Process
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203-2023

John Weeks Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203

John Weeks Culclasure, M.D.
Saint Thomas Outpatient Neurological Center
4230 Harding Pike, Suite 901
Nashville, Tennessee 37205

Debra V. Schamberg, R.N.
Nashville, Tennessee 37217

Debra V. Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, Tennessee 37203

Debra V. Schamberg, R.N.
Saint Thomas Outpatient Neurological Center
4230 Harding Pike, Suite 901
Nashville, Tennessee 37205

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Phillip Tyree Patient Identifier:

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider Saint Thomas Outpatient Neurological Center

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

or any representative, attorney or investigator from said organization or person.

Purpose of the Requested Use or Disclosure

Expiration and Revocation of This Authorization

Expiration Date or Event: _____

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

X Phillip B Tyree 8-8-2013
Signature (Patient) Date

X Shatika Boards 8-8-13
Signature (Witness)

Signature (Authorized Representative) Date

Relationship to Patient

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Ferguson, et al. v. Ameridose, et al.,
No. 1:13-cv-12571-FDS, Compl. Ex. 7A

Deficiency:

Release does not include the signature and date of the patient or patient's representative's authorization[4]

Provision Violated:

45 C.F.R. § 164.508(c)(1)(vi), which requires a HIPAA release contain the signature of the individual authorizing the release and the date of the authorization

[4] Interestingly, the HIPAA releases attached to the Plaintiffs' Complaint, and which were testified to as true and accurate copies of the HIPAA releases sent to the office of counsel, are not identical copies of the HIPAA releases sent to counsel. This is attested to in the affidavit filed with this Memorandum of Law. For the Court's convenience, counsel also includes copies of the HIPAA releases sent to counsel. As the Court will note, all of the HIPAA releases sent to counsel do not include the signature date. Only one of the HIPAA releases filed by the Plaintiffs does not include the signature date.

English Lucas Priest & Owsley, LLP | *Strength. Knowledge. Experience.*

Writer's e-mail address: byoung@elpolaw.com

June 28, 2013

Via Certified Mail

St. Thomas Outpatient Neurosurgical Center, LLC
a/k/a St. Thomas Outpatient Neurosurgery Center/Clinic
c/o Matthew H. Cline
Gideon, Cooper & Essary, PLC
Regions Center, Suite 1100
315 Deadrick Street
Nashville, Tennessee 37238

Re: Rosemary Ferguson
162 Luncford Rd.
Leoma, TN 38468
DOB: /1956

To Whom It May Concern:

The below is a list of health care providers to whom notice is being given, pursuant to T.C.A. §29-26-121(a), of a potential claim for medical malpractice involving steroid injections administered at St. Thomas Outpatient Neurosurgical Clinic between May 21, 2012 and September 28, 2012.

1. St. Thomas Outpatient Neurosurgical Center, LLC
a/k/a St. Thomas Outpatient Neurosurgery Center/Clinic
c/o Matthew H. Cline
Gideon, Cooper & Essary, PLC
Regions Center, Suite 1100
315 Deadrick Street
Nashville, Tennessee 37238

2. New England Compounding Pharmacy, Inc.
c/o Daniel Cohn, Esq.
Murtha Cullina, LLP
99 High Street, 20th Floor
Boston, MA 02110

1101 COLLEGE ST., PO BOX 770
BOWLING GREEN, KY 42102
P 270.781.6500
F 270.782.7782
W WWW.ELPOLAW.COM

Exhibit 7A

3. Ameridose LLC
   c/o Jane F. Warner
   Tucker Ellis LLP
   925 Euclid Avenue, Suite 1150
   Cleveland, Ohio 44115-1414

4. Gregory Conigliaro
   205 Flanders Road
   Westborough, MA 01581

5. Barry Cadden
   205 Flanders Road
   Westborough, MA 01581

6. John Culclasure, M.D.
   Howell Allen Clinic
   2011 Murphy Avenue, Suite 301
   Nashville, TN 37203

7. Howell Allen Clinic
   Attn: Gregory B. Lanford, M.D.
   Registered Agent
   2011 Murphy Avenue, Suite 301
   Nashville, TN 37203

8. St. Thomas Hospital
   Attn: Dawn Rudolph
   Chief Executive Officer
   4220 Harding Road
   Nashville, TN 37205

9. Saint Thomas Network
   4220 Harding Pike
   Nashville, TN 37205-2005

10. Saint Thomas Network
    c/o E. Berry Holt, III
    102 Woodmont Boulevard, Suite 800
    Nashville, TN 37205-2221

Exhibit 7A

11. Saint Thomas Health
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

12. Saint Thomas Health
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

13. St. Thomas Hospital
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

14. St. Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

15. St. Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Pike, Suite 901
Nashville, TN 37205

16. Debra V. Schamberg, RN
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

17. Debra V. Schamberg, RN
Saint Thomas Outpatient Neurosurgical Center
4230 Harding Pike, Suite 901
Nashville, TN 37205

18. Patricia G. Beckham
Baptist Women's Pavilion
2011 Murphy Avenue
Nashville, TN 37203

Exhibit 7A

Please give me a call if you have any questions.

Very truly yours,

ENGLISH, LUCAS, PRIEST & OWSLEY, LLP

Robert A. Young

RAY/tg

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	
Provider's/Health Plan's Name:	**Recipient's Name:**	
Howell Allen Clinic		
Provider's/Health Plan's Address:	Address 1:	
2011 Murphy Ave., Suite 301 Nashville, TN 37203	Address 2:	
	City: / State: / Zip:	

This authorization will expire on the following: (Fill in the Date or the Event but not both)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☐ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing information ☑ Transfer forms ☑ ER information		☑ Labor/delivery sum. ☑ DC nursing assess ☑ Postpartum flow sheet ☑ Itemized bill ☑ UB 92 ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	
Provider's/Health Plan's Name:	**Recipient's Name:**	
Howell Allen Clinic		
Provider's/Health Plan's Address:	**Address 1:**	
2011 Murphy Avenue, Suite 301 Nashville, TN 37203	**Address 2:**	
	City:	**State:** **Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? If Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☒ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☒ Special test/therapy ☐ Rhythm Strips ☒ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HI results or AIDS information. _____ (Initial) If not applicable, check here: ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 6-21-13
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	
Provider's/Health Plan's Name: St. Thomas Out-Patient Neurosurgery Center	Recipient's Name:	
Provider's/Health Plan's Address: 4230 Harding Pike, Medical Plaza East, Suite 810, Nashville, TN 37205	Address 1:	
	City:	State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets		☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Consult forms ☒ ER Information		☒ Labor/delivery sum. ☒ OB nursing notes ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date: 6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	
Provider's/Health Plan's Name:	**Recipient's Name:**	
St. Thomas Out-Patient Neurosurgery Center		
Provider's/Health Plan's Address:	**Address 1:**	
4230 Harding Pike Medical Plaza East, Suite 810 Nashville, TN 37205	**Address 2:**	
	City:	**State:** T **Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description	Date(s)
☐ All PHI in medical record ☒ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☒ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, H results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care providers] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Hospital	
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill ☑ UB-92 ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained, through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date: 6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Hospital	
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☑ All PHI in medical record		☑ Operative information		☑ Labor/delivery sum.	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☑ Physician orders		☐ Rhythm Strips		☐ Itemized bill	
☐ Intake/outtake		☐ Nursing Information		☑ UB-92	
☐ Clinical Test		☑ Transfer forms		☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc.	
☐ Medication Sheets		☑ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, H results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C Ferguson	Date: 6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	

Provider's/Health Plan's Name:	Recipient's Name:
Dr.. Frances Berry Brown	
Provider's/Health Plan's Address: 233 East Gaines Lawrenceburg, TN 38464	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All EMR in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ Nursing notes ☑ Postpartum flow sheet ☑ Itemized bill: ☑ H&P: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. RCY (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date: 6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1958	
Provider's/Health Plan's Name:	**Recipient's Name:**	
Dr. Frances Berry Brown		
Provider's/Health Plan's Address:	**Address:**	
233 East Gaines Lawrenceburg, TN 38464	**Address 2:**	
	City: / **State:** / **Zip:**	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of Disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? If Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☑ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer form ☐ ER Information		☐ Labor/delivery summ. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☑ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, H results or AIDS information. _____ (initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	

Provider's/Health Plan's Name:	Recipient's Name:
Vanderbilt Comprehensive Spine Center	
Provider's/Health Plan's Address: 719 Thompson Ln. #23108 Nashville, TN 37204	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets		☒ Operative information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information		☒ Labor/delivery sum ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92 ☒ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information: ____ (Initial) If not applicable, check here. ☐

I understand that:
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5. I understand that I/my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date: 6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	

Provider's/Health Plan's Name:	Recipient's Name:
Vanderbilt Comprehensive Spine Center	
Provider's/Health Plan's Address:	Address 1:
719 Thompson Ln. #23108 Nashville, TN 37204	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? If Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strip ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill ☐ UB-92s ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

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5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this low-fees records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	956	

Provider's/Health Plan's Name:	Recipient's Name:
Vanderbilt Medical Group	
Provider's/Health Plan's Address: 1211 22nd Avenue South, Room B-334, VUH, Nashville, TN 37232	Address 1:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☑ All PHI in medical record ☐ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☐ Medication Sheets		☑ Operative information ☑ Cath lab ☐ Special test/therapy ☑ Rhythm Strips ☑ Nursing information ☑ Transfer form ☐ ER information		☑ Labor/delivery sum. ☑ OB nursing notes ☑ Postpartum flow sheet ☐ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
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5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	
Provider's/Health Plan's Name: Vanderbilt Medical Group	Recipient's Name:	
Provider's/Health Plan's Address: 1211 22nd Avenue South, Room B-334, VUH, Nashville, TN 37232	Address 1:	
	Address 2:	
	City:	State: Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, H results or AIDS information. _____ (initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is entirely voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date: 6-21-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

Exhibit 7A

English Lucas Priest & Owsley, LLP | *Strength. Knowledge. Experience.*

Writer's e-mail address: byoung@elpolaw.com

June 28, 2013

Via Certified Mail

St. Thomas Outpatient Neurosurgical Center, LLC
a/k/a St. Thomas Outpatient Neurosurgery Center/Clinic
c/o Matthew H. Cline
Gideon, Cooper & Essary, PLC
Regions Center, Suite 1100
315 Deadrick Street
Nashville, Tennessee 37238

Re: Rosemary Ferguson
162 Luncford Rd.
Leoma, TN 38468
DOB: /1956

To Whom It May Concern:

The below is a list of health care providers to whom notice is being given, pursuant to T.C.A. §29-26-121(a), of a potential claim for medical malpractice involving steroid injections administered at St. Thomas Outpatient Neurosurgical Clinic between May 21, 2012 and September 28, 2012.

1. St. Thomas Outpatient Neurosurgical Center, LLC
a/k/a St. Thomas Outpatient Neurosurgery Center/Clinic
c/o Matthew H. Cline
Gideon, Cooper & Essary, PLC
Regions Center, Suite 1100
315 Deadrick Street
Nashville, Tennessee 37238

2. New England Compounding Pharmacy, Inc.
c/o Daniel Cohn, Esq.
Murtha Cullina, LLP
99 High Street, 20th Floor
Boston, MA 02110

3. Ameridose LLC
   c/o Jane F. Warner
   Tucker Ellis LLP
   925 Euclid Avenue, Suite 1150
   Cleveland, Ohio 44115-1414

4. Gregory Conigliaro
   205 Flanders Road
   Westborough, MA 01581

5. Barry Cadden
   205 Flanders Road
   Westborough, MA 01581

6. John Culclasure, M.D.
   Howell Allen Clinic
   2011 Murphy Avenue, Suite 301
   Nashville, TN 37203

7. Howell Allen Clinic
   Attn: Gregory B. Lanford, M.D.
   Registered Agent
   2011 Murphy Avenue, Suite 301
   Nashville, TN 37203

8. St. Thomas Hospital
   Attn: Dawn Rudolph
   Chief Executive Officer
   4220 Harding Road
   Nashville, TN 37205

9. Saint Thomas Network
   4220 Harding Pike
   Nashville, TN 37205-2005

10. Saint Thomas Network
    c/o E. Berry Holt, III
    102 Woodmont Boulevard, Suite 800
    Nashville, TN 37205-2221

11. Saint Thomas Health
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

12. Saint Thomas Health
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

13. St. Thomas Hospital
c/o E. Berry Holt, III
102 Woodmont Boulevard, Suite 800
Nashville, TN 37205-2221

14. St. Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

15. St. Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Pike, Suite 901
Nashville, TN 37205

16. Debra V. Schamberg, RN
Howell Allen Clinic
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

17. Debra V. Schamberg, RN
Saint Thomas Outpatient Neurosurgical Center
4230 Harding Pike, Suite 901
Nashville, TN 37205

18. Patricia G. Beckham
Baptist Women's Pavilion
2011 Murphy Avenue
Nashville, TN 37203

Please give me a call if you have any questions.

Very truly yours,

ENGLISH, LUCAS, PRIEST & OWSLEY, LLP

Robert A. Young

RAY/tg

SAMPLE HIPAA FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Rosemary C. Ferguson	956	
Provider's/Health Plan's Name:	**Recipient's Name:**	
Howell Allen Clinic		
Provider's/Health Plan's Address:	Address 1:	
2011 Murphy Ave., Suite 301 Nashville, TN 37203	Address 2:	
	City:	State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
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5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	

Provider's/Health Plan's Name:	Recipient's Name:
Howell Allen Clinic	

Provider's/Health Plan's Address:	Address 1:		
2011 Murphy Avenue, Suite 301 Nashville, TN 37203	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

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I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

SAMPLE HIPAA FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Out-Patient Neurosurgery Center	

Provider's/Health Plan's Address:	Address 1:		
4230 Harding Pike Medical Plaza East, Suite 810 Nashville, TN 37205	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Out-Patient Neurosurgery Center	

Provider's/Health Plan's Address:	Address 1:		
4230 Harding Pike Medical Plaza East, Suite 810 Nashville, TN 37205	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

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Section B:

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Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

SAMPLE AUTHORIZATION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Rosemary C. Ferguson	/1956	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Hospital	

Provider's/Health Plan's Address:	Address 1:		
4220 Harding Road Nashville, TN 37205	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

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Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	

Provider's/Health Plan's Name:	Recipient's Name:
St. Thomas Hospital	
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

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6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date:
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

SAMPLE HIPAA FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	

Provider's/Health Plan's Name:	Recipient's Name:
Dr.. Frances Berry Brown	
Provider's/Health Plan's Address: 233 East Gaines Lawrenceburg, TN 38464	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

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Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date:
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	

Provider's/Health Plan's Name:	Recipient's Name:
Dr. Frances Berry Brown	
Provider's/Health Plan's Address: 233 East Gaines Lawrenceburg, TN 38464	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

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5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date:
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

SAMPLE HIPAA FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	956	

Provider's/Health Plan's Name:	Recipient's Name:
Vanderbilt Comprehensive Spine Center	
Provider's/Health Plan's Address: 719 Thompson Ln. #23108 Nashville, TN 37204	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
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Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date:
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	

Provider's/Health Plan's Name:	Recipient's Name:
Vanderbilt Comprehensive Spine Center	
Provider's/Health Plan's Address: 719 Thompson Ln. #23108 Nashville, TN 37204	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

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Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date:
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

SAMPLE HIPAA FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	1956	

Provider's/Health Plan's Name:	Recipient's Name:
Vanderbilt Medical Group	

Provider's/Health Plan's Address:	Address 1:		
1211 22nd Avenue South Room B-334, VUH Nashville, TN 37232	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☑ All PHI in medical record ☑ Admission form ☑ Dictation reports ☑ Physician orders ☑ Intake/outtake ☑ Clinical Test ☑ Medication Sheets		☑ Operative Information ☑ Cath lab ☑ Special test/therapy ☑ Rhythm Strips ☑ Nursing Information ☑ Transfer forms ☑ ER Information		☑ Labor/delivery sum. ☑ OB nursing assess ☑ Postpartum flow sheet ☑ Itemized bill: ☑ UB-92: ☑ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Rosemary C. Ferguson	
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Rosemary C. Ferguson	/1956	
Provider's/Health Plan's Name: Vanderbilt Medical Group	**Recipient's Name:**	
Provider's/Health Plan's Address: 1211 22nd Avenue South, Room B-334, VUH, Nashville, TN 37232	**Address 1:**	
	Address 2:	
	City:	**State:** T **Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

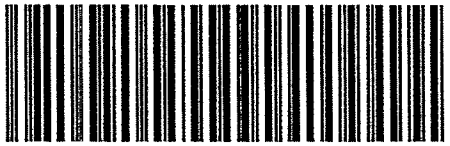
I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson	Date:
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

RETURN RECEIPT REQUESTED ELECTRONICALLY

Robert A. Young
English, Lucas, Priest and Owsley, LLP
PO Box 770
Bowling Green KY 42102-0770



7118 9042 9551 1455 1282

SEQ# 0000017

St. Thomas Outpatient Neurosurgical Cent
c/o Matthew H. Cline
315 Deadrick Street
Regions Center, Suite 1100
Nashville TN 37238

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Higdon, et al. v. Ameridose, et al.,
No. 1:13-cv-12718, Compl. Ex. F

Deficiency:

Release does not include a statement regarding the ability or inability of a health care provider to condition treatment contingent on the patient signing the authorization[5]

Provision Violated:

45 C.F.R. § 164.508(c)(2)(ii), which requires a HIPAA release contain a statement regarding the ability or inability of a health care provider to condition treatment contingent on the patient signing the authorization

[5] Other Plaintiffs who failed to include a statement regarding conditioning of treatment, *e.g.*, *Alexander, Lapiska, Nealon, Peay, and Schulz*, did not attach their HIPAA releases to their Complaints in violation of Tenn. Code Ann. § 29-26-121(b). Failure to comply with Tenn. Code Ann. § 29-26-121(b) is an independent ground for dismissal. *Vaughn,* E2012-01042-COA-R3-CV, 2013 WL 817032, at *6; *Miller,* No. 2:13-cv-02149-JPM-dkv, 2013 WL 4097340, at *5. Therefore, the Plaintiffs' Complaints in *Alexander, Lapiska, Nealon, Peay, and Schulz* should be dismissed for failure to comply with Tenn. Code Ann. § 29-26-121(a)(2)(E) and (b), in addition to failing to include the above statement in the release.

EVANS | PETREE PC
ATTORNEYS AT LAW

J. STEPHEN KING
JKING@EVANSPETREE.COM
DIRECT FAX 901.374.7548

February 15, 2013

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

RE: Notice of Claim for Medical Malpractice
Shirley R. Higdon
DOB: /1938
MRN#: SC24325

Gentlemen:

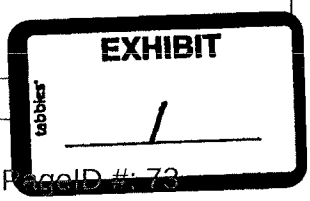
Please be advised that this office represents Shirley R. Higdon whose date of birth is November 13, 1938. Mrs. Higdon is the patient whose treatment is the subject of this notice and claim.

I am the attorney representing Shirley R. Higdon. My name and address are:

J. Stephen King
Evans | Petree PC
1000 Ridgeway Loop Road, Suite 200
Memphis, Tennessee 38120

The name and address of all healthcare providers against whom this claim is being made and to whom notice is being provided are as follows:

Name	Current Business Address	Dept. of Health website address
St. Thomas Outpatient Neurosurgical Center	4230 Harding Road, Suite 901 Nashville, TN 37205	Debra Schamberg 4230 Harding Road, Suite 901 Nashville, TN 37205
Howell Allen Clinic	2011 Murphy Avenue Suite 301 Nashville, TN 37203 Attn: Gregory B. Lunford, M.D., Registered Agent	



E|P

Saint Thomas Network	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III
Saint Thomas Health	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III	
Saint Thomas Hospital	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: Dawn Rudolph

Enclosed is a HIPAA client medical authorization signed by Mrs. Higdon permitting you to obtain complete medical records from each healthcare provider being sent this notice.

Sincerely,

James Stephen King

JSK/lrs
Enclosure
cc: Mrs. Shirley R. Higdon

Gregory B. Lunford. M.D.
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023

LIMITED AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this Authorization is to comply with the requirements of T.C.A. 29-26-121, and allows persons or entities listed in a T.C.A 29-26-121 Notice Letter to obtain copies of Shirley Higdon's (hereinafter referred to as "Patient") medical records.

This Authorization allows you to provide a copy of Patient's medical records to the persons or entities listed in the attached Notice letter. Patient further requests that you provide a copy of those same records to Patient's attorneys, Evans Petree PC at the time you provide copies of the record pursuant to this Authorization.

THIS AUTHORIZATION DOES NOT ALLOW YOU TO DISCUSS PATIENT, OR PATIENT'S MEDICAL RECORDS WITH ANY OTHER HEALTH CARE PROVIDER, OR ATTORNEY.

PATIENT SPECIFICALLY MAINTAINS THE RIGHTS OF CONFIDENTIALITY PROVIDED BY ALL APPLICABLE STATE AND FEDERAL LAW.

Revocation: This Authorization may be revoked in writing, at any time, except where it has already been used and relied on it to make a use or disclosure. Written revocation will become effective once it is processed and received. Consequences of Signing this Form: Please be aware that re-disclosure may lead to the loss of protected status.

PATIENT'S FULL NAME: Shirley Higdon

ADDRESS: 931 Jeanette Holladay Road, Parsons, Tennessee 38363
DOB: /1938 SSN: -5655

I authorize the **persons listed on the attached notice provider list** to use and disclose to THE PERSONS NAMED IN THE ATTACHED PROVIDER NOTICE LETTER the complete medical record of the patient identified above. The purpose or need for the information is to comply with T.C.A. 29-26-121. Patient further requests that you provide an exact copy of the same records to Plaintiff's Attorneys, Evans Petree PC at the time you provide copies of the record pursuant to this Authorization.

Expiration: This Authorization expires on the date you specify below or six months from the date signed, whichever is earlier. Once this Authorization expires, we will no longer use and disclose your health information for the described purposes unless you sign a new Authorization Form.

This Authorization expires: Y in six (6) months; or on the following date:_____

Shirley Higdon
Signature of Patient or Personal Representative

Shirley Higdon
Printed Name of Patient

Date: 2/18/2013

*If Personal Representative, the Patient is unable to sign because of :_____Minor; _____Incompetent; _____ Deceased; _____ Other (Explain:_____)

K:\SKing\FORMS JSK\Medical Authorization.docx

EVANS | PETREE PC
ATTORNEYS AT LAW

J. STEPHEN KING
JKING@EVANSPETREE.COM
DIRECT FAX 901.374.7548

February 15, 2013

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

St. Thomas Outpatient Neurosurgical Center
Debra Schamberg
4230 Harding Road, Suite 901
Nashville, TN 37205

RE: Notice of Claim for Medical Malpractice
Shirley R. Higdon
DOB: /1938
MRN#: SC24325

Gentlemen:

Please be advised that this office represents Shirley R. Higdon whose date of birth is November 13, 1938. Mrs. Higdon is the patient whose treatment is the subject of this notice and claim.

I am the attorney representing Shirley R. Higdon. My name and address are:

J. Stephen King
Evans | Petree PC
1000 Ridgeway Loop Road, Suite 200
Memphis, Tennessee 38120

The name and address of all healthcare providers against whom this claim is being made and to whom notice is being provided are as follows:

Name	Current Business Address	Dept. of Health website address
St. Thomas Outpatient Neurosurgical Center	4230 Harding Road, Suite 901 Nashville, TN 37205	Debra Schamberg 4230 Harding Road, Suite 901 Nashville, TN 37205
Howell Allen Clinic	2011 Murphy Avenue Suite 301 Nashville, TN 37203	

E|P

	Attn: Gregory B. Lunford, M.D., Registered Agent	
Saint Thomas Network	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III
Saint Thomas Health	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III	
Saint Thomas Hospital	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: Dawn Rudolph

Enclosed is a HIPAA client medical authorization signed by Mrs. Higdon permitting you to obtain complete medical records from each healthcare provider being sent this notice.

Sincerely,

James Stephen King

JSK/lrs
Enclosure
cc: Mrs. Shirley R. Higdon

Gregory B. Lunford. M.D.
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023

LIMITED AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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This Authorization allows you to provide a copy of Patient's medical records to the persons or entities listed in the attached Notice letter. Patient further requests that you provide a copy of those same records to Patient's attorneys, Evans Petree PC at the time you provide copies of the record pursuant to this Authorization.

THIS AUTHORIZATION DOES NOT ALLOW YOU TO DISCUSS PATIENT, OR PATIENT'S MEDICAL RECORDS WITH ANY OTHER HEALTH CARE PROVIDER, OR ATTORNEY.

PATIENT SPECIFICALLY MAINTAINS THE RIGHTS OF CONFIDENTIALITY PROVIDED BY ALL APPLICABLE STATE AND FEDERAL LAW.

Revocation: This Authorization may be revoked in writing, at any time, except where it has already been used and relied on it to make a use or disclosure. Written revocation will become effective once it is processed and received. Consequences of Signing this Form: Please be aware that re-disclosure may lead to the loss of protected status.

PATIENT'S FULL NAME: Shirley Higdon

ADDRESS: 931 Jeanette Holladay Road, Parsons, Tennessee 38363
DOB: /1938 SSN: -5655

I authorize the **persons listed on the attached notice provider list** to use and disclose to THE PERSONS NAMED IN THE ATTACHED PROVIDER NOTICE LETTER the complete medical record of the patient identified above. The purpose or need for the information is to comply with T.C.A. 29-26-121. Patient further requests that you provide an exact copy of the same records to Plaintiff's Attorneys, Evans Petree PC at the time you provide copies of the record pursuant to this Authorization.

Expiration: This Authorization expires on the date you specify below or six months from the date signed, whichever is earlier. Once this Authorization expires, we will no longer use and disclose your health information for the described purposes unless you sign a new Authorization Form.

This Authorization expires: X in six (6) months; or on the following date:_____

Shirley Higdon
Signature of Patient or Personal Representative

Shirley Higdon
Printed Name of Patient

Date: 2/18/2013

*If Personal Representative, the Patient is unable to sign because of :_____Minor; _____Incompetent; _____ Deceased; _____ Other (Explain:_____)

K:\SKing\FORMS JSK\Medical Authorization.docx

EXAMPLE OF NON-COMPLIANT HIPAA AUTHORIZATION

Lapiska v. Ameridose, et al.,
No. 1:13-cv-12914

Deficiency:

Release does not include a statement regarding the potential for information disclosed pursuant to the authorization to be subject to re-disclosure and no longer protected by HIPAA

Provision Violated:

45 C.F.R. § 164.508(c)(2)(iii), which requires a HIPAA release contain a statement regarding the potential for information disclosed pursuant to the authorization to be subject to re-disclosure and no longer protected by HIPAA

LAW OFFICES
Gilreath & Associates, PLLC
BANK OF AMERICA CENTER
550 MAIN AVENUE, SUITE 600
P.O. BOX 1270
KNOXVILLE, TENNESSEE 37901-1270
TELEPHONE 865/637-2442
FACSIMILE 865/971-4116
www.sidgilreath.com

SIDNEY GILREATH
R. CHRISTOPHER GILREATH
CARY L. BAUER
TIMOTHY HOUSHOLDER
GINGER PICKARD

NASHVILLE OFFICE
222 SECOND AVENUE NORTH
SUITE 417
NASHVILLE, TENNESSEE 37201
615/726-5588

MEMPHIS OFFICE
ONE MEMPHIS PLACE
200 JEFFERSON AVENUE, SUITE 711
MEMPHIS, TENNESSEE 38103
901/527-0511

September 17, 2013

Via Certified Mail - Return Receipt Requested

Specialty Surgery Center, PLLC
c/o Ron Calisher, Administrator
116 Brown Avenue
Crossville, TN 38555

RE: William Lapiska
Notice Required by T.C.A. § 29-26-121(a)

Dear Mr. Calisher:

I represent William Lapiska. Through me and my firm, he is asserting a potential claim for medical malpractice against you. This claim arises out of the treatment Mr. Lapiska received at Specialty Surgery Center on September 18, 2012, wherein he received an injection of an epidural steroid manufactured by New England Compounding Center, which resulted in an a spinal fungal abscess at the site of the tainted injection. Mr. Lapiska was referred to an infectious disease specialist where he had two MRI's and a spinal tap followed by a third MRI. Mr. Lapiska was then referred to a neurologist who drained the abscess while Mr. Lapiska was hospitalized at Cookeville Regional Medical Center. Mr. Lapiska was then required to take antifungal medication for a prolonged amount of time.

The full name and date of birth of the patient whose treatment is at issue are:

William Lapiska
Date of Birth: /1928

The name and address of the claimant authorizing this notice and the relationship to the patient are:

William Lapiska (patient)
248 Lakewood Drive
Fairfield Glade, TN 38558

The name and address of the attorney sending this notice are:

Timothy A. Housholder, Attorney
Gilreath & Associates
550 Main Avenue, Suite 600
Knoxville, TN 37902

Enclosed is a HIPPA-compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice.

Attached is a list of all healthcare providers to whom notice is being given pursuant to T.C.A. §29-26-121(a). Please have your professional liability insurance carrier's representative, or other appropriate person, contact me soon.

Yours truly,

TIMOTHY A. HOUSHOLDER

TH/kfl

Enclosure

HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO T.C.A. §29-26-121

PATIENT NAME: WILLIAM LAPISKA
DATE OF BIRTH: 1928
SOCIAL SECURITY NO: -6771
DATES OF TREATMENT: 9/18/2012 – Present

I, William Lapiska, authorize:

Specialty Surgery Center, PLLC

to obtain my complete medical records from:

Kenneth R. Lister, M.D.

This authorization is granted under HIPAA (the Health Insurance Portability and Accountability Act of 1996) to include all records information data in the possession of the above-named, including hospital, doctor, dental, psychiatric, pharmacy, therapy, and all other records.

I may revoke this authorization at any time. This authorization will expire when revoked by me or when the undersigned's representation by Gilreath & Associates, PLLC is concluded.

All medical records obtained pursuant to this authorization shall be copied and a copy shall be furnished to my attorneys in the care of Timothy A. Housholder, 550 Main Avenue, Suite 600, Knoxville, TN 37902 within five (5) days after the records are obtained.

A photocopy of this authorization is to be considered as valid as the original.

THIS AUTHORIZATION DOES NOT PERMIT ANYONE TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVE OUTSIDE THE PRESENCE OF MY ATTORNEY.

This 17th day of September, 20 13.

William Lapiska

PATIENT (Personal Representative)

LIST OF HEALTHCARE PROVIDERS TO WHOM NOTICE IS BEING GIVEN PURSUANT TO TCA § 29-26-121(A)

RE: WILLIAM LAPISKA

The following is a list of all healthcare providers to whom notice is being given, pursuant to Tennessee Code Annotated Section 29-26-121(a), of a potential claim for medical malpractice:

1. Dr. Kenneth R. Lister, M.D.
   116 Brown Avenue
   Crossville, TN 38555

2. Dr. Kenneth R. Lister, M.D.
   Outpatient Anesthesia
   2761 Sullins Street
   Knoxville, TN 37919

3. Specialty Surgery Center, PLLC
   116 Brown Avenue
   Crossville, TN 38555